Complete Summary

GUIDELINE TITLE

Evidence-based clinical practice guideline. Continence for women.

BIBLIOGRAPHIC SOURCE(S)

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Continence for women. Evidence-based practice guideline. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); 2000 Jan. 27 p. [65 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Urinary incontinence, including:

- Stress incontinence
- Urge incontinence
- Mixed urge and stress incontinence

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Obstetrics and Gynecology
Urology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses

GUIDELINE OBJECTIVE(S)

- To help nurses apply research-based knowledge in the care of women from the childbearing years through senescence who are at risk for or who have urinary incontinence
- To provide the registered and advanced practice nurse in acute, ambulatory, assisted living, and home care settings with information necessary to accomplish the following:
    - Identify and assess women for the presence of urinary incontinence
    - Conduct a basic evaluation to determine the need for behavioral self-care education to prevent or treat urinary incontinence
    - Implement behavioral therapies including scheduled voiding regimens, pelvic floor muscle training (PFMT), biofeedback and dietary and lifestyle modifications (for women likely to benefit)
    - Treat or make referrals for women who may require concomitant pharmacotherapy
    - Make referrals for more specialized levels of care

TARGET POPULATION

Screening

All women from the childbearing years (including adolescents and young student athletes) through senescence who have been or may be affected by urinary incontinence

Treatment

Women from the childbearing years through senescence who have been or may be affected by urinary incontinence and who are capable of responding to behavioral therapies or care-provider-assisted training

INTERVENTIONS AND PRACTICES CONSIDERED

Screening/Diagnosis

1. Urinary history and relevant health history

2. Physical examination (abdominal, pelvic and rectal)
3. Urine dipstick (If urinary tract infection, treatment and reassessment)
4. Cough stress test
5. Postvoid residual volume by catheter or bladder ultrasound
6. Bladder diary

Management/Treatment

1. Treatment decision-making based on incontinence type, pattern and severity and patient lifestyle preferences and motivation
2. Risk reduction measures:
    a. Medication modifications if possible
    b. Fluid modifications
    c. Caffeine reduction
    d. Constipation prevention
    e. Weight reduction (if morbidly obese)
    f. Smoking cessation
    g. Super tampon/pessary for exercise-induced incontinence
    h. Environmental modifications for mobility impairments
    i. Physical therapy for mobility impairments
    j. Clothing modifications for manual dexterity impairments
3. Timed voiding
4. Bladder training (BT)
5. Pelvic floor muscle training (PFMT)
6. Biofeedback-assisted pelvic floor muscle training
7. Combination training (bladder training and pelvic floor muscle training)
8. Concomitant pharmacotherapy (anticholinergic agents, such as oxybutynin, propantheline bromide; alpha-adrenergic agents, such as phenylpropanolamine*, pseudoephedrine; estrogen in combination with alpha-adrenergic agents, phenylpropanolamine hydrochloride*)

    Note from the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): The above-mentioned drug treatments refer to treatment modalities available at the time of publication of the original guideline (2000 Jan) and are subject to change with the development of additional pharmacological agents.

9. Consultation and/or referral as appropriate

*Note from the National Guideline Clearinghouse (NGC): In June 2001, The Food and Drug Administration (FDA) issued a public health advisory for the use of phenylpropanolamine (PPA) and is taking steps to remove PPA from all drug products. They have also requested that all drug companies discontinue marketing products containing PPA. For more information on this public health advisory, please see the U.S. Food and Drug Administration Center for Drug Evaluation and Research (CDER) Web site.

MAJOR OUTCOMES CONSIDERED

- Rates of urinary incontinence
- Efficacy of treatment in reducing incontinent episodes and improving quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

II-3: Evidence from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Association of Women´s Health, Obstetric and Neonatal Nurses (AWHONN) template for guideline development is based on the framework delineated in the American Nurses Association (ANA) Manual to Develop Guidelines (Marek KD, American Nurses Association Committee on Nursing Practices, Standards and Guidelines. Washington [DC]: American Nurses Publishing, American Nurses

Foundation, American Nurses Association, 1995). The American Nurses Association Manual to Develop Guidelines models its process on that of the Agency for Healthcare Research Quality (AHRQ), formerly the Agency for Health Care Policy and Research (AHCPR).

Guideline team members participated throughout 1999 in teleconferences and literature review, evaluation and scoring. A system and tool for scoring the literature was developed based on the method for literature analysis presented in the American Nurses Association Manual to Develop Guidelines (Marek, 1995). Using this framework, each study reviewed by the guideline team was evaluated according to the following eight categories:

1. Problem or question studied
2. Sampling
3. Measurement
4. Internal validity
5. External validity
6. Construct validity
7. Statistical conclusion validity
8. Justification for conclusions

A description of the above criteria and a sample tool is included in Appendix A in the original guideline document.

As the evidence-based clinical practice guideline was further developed, the quality of evidence supporting clinical practice recommendations was determined by team consensus using the U.S. Preventive Services Task Force (1996) Guide to Clinical Preventive Services quality of evidence rating scale presented in Appendix B of the original guideline document.

Each clinical practice recommendation presented in the guideline is supported by a referenced rationale using American Psychological Association (APA) citation format. The column headed Evidence Rating includes the quality of evidence ratings for each reference cited under the column headed Referenced Rationale. Full citations for all references are given in the reference list of the original guideline document.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Following literature scoring, team members were assigned to develop individual elements of the guideline:

1. Screening for urinary infection
2. Basic evaluation and clinical assesment
3. Treatment decision making process
4. Interventions

5. Referral

Weekly teleconferences enabled members to review each of the above elements and achieve consensus on each clinical practice recommendation, accompanying referenced rationale and quality of evidence ratings.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
Comparison with Guidelines from Other Groups
Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

- This guideline was peer reviewed by a panel of Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) expert members.
- Clinical validation and pilot testing was conducted via AWHONNs Research Based Practice Project; the guideline was implemented by nurses in selected clinical sites prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Quality of Evidence Ratings (I through III) are defined at the end of the "Major Recommendations" field.

Screening for Urinary Incontinence

1. All adult women should be screened for the presence of urinary incontinence (UI) (Diokno et al., 1986: Evidence Rating: II-3) (Burgio et al., 1991: Evidence Rating: III).
2. These screening questions should be incorporated into the history that is routinely collected during a clinic visit:
    a. Do you ever leak urine/water when you don't want to?
    b. Do you ever leak urine when you cough, laugh or exercise?
    c. Do you ever leak urine on the way to the bathroom?
    d. Do you ever use pads, tissue or cloth in your underwear to catch urine?

(Diokno et al., 1986: Evidence Rating: II-3) (Burgio et al., 1991; Harrison & Memel, 1994: Evidence Rating: III)

3. Careful attention should be directed to groups at higher risk for urinary incontinence:
    a. Pregnant and postpartum women
    b. Women with visual, cognitive or physical limitations
    c. Elderly women

    (Sleep & Grant, 1987; Sampselle et al., 1998; McDowell et al., 1999: Evidence Rating: I) (Resnick et al., 1994: Evidence Rating: II-3)

Basic Evaluation and Clinical Assessment

1. If during the screening process the woman report urinary incontinence, the nurse should obtain additional basic evaluation data (Wyman et al., 1997: Evidence Rating: I) (Fantl et al., 1996: Evidence Rating: III)
    a. Urinary history:
        - Duration of the urinary incontinence
        - Severity, i.e., amount of leakage
        - Impact on the quality of life
        - Diurnal frequency of incontinence
        - Nocturia
        - Nocturnal enuresis
        - Presence of urinary tract infection (UTI) symptoms
        - Previous treatment program, surgery or medication for urine loss problems
    b. Relevant health history:
        Rule out history of the following:
        - Diabetes
        - Multiple sclerosis
        - Mobility limitations
        - Memory impairment
        - Spinal cord injury or surgery on spinal cord
        - Stroke
        - Other neurologic conditions

    (Fantl et al., 1996: Evidence Rating: III)

2. The physical examination in the evaluation of urinary incontinence may be conducted by the advance practice nurse, the primary health care provider, or the gynecologist and includes the following basic assessment:
    a. Abdominal exam to rule out the following:
        - Diastasis recti
        - Organomegaly
        - Masses
        - Peritonitis
        - Fluid collections
    b. Pelvic and rectal exam to evaluate the following:
        - Perineal sensation
        - The "anal wink"
        - Prolapse of the uterus, cystocele or rectocele

- Palpation of the anterior vaginal wall and urethra to assess for abnormalities
- Vaginal atrophy
- Ability to isolate and contract the pelvic floor muscles
- Fecal impaction
- Rectal mass

c. Additional assessments:
- Direct observation of urine loss during a cough
- Estimation of postvoid residual (PVR) volume by palpation, percussion, bladder ultrasound or urinary catheterization
- Patient use of a bladder diary to determine frequency, timing and amount of voiding and urine leakage (see Appendix C in the original guideline document)

(Fantl et al., 1996: Evidence Rating: III)

3. A routine urine dipstick test should be used to screen for conditions that are associated with incontinence:
   a. Bacteriuria and pyuria by dipstick should be followed up with a urine culture (Lach et al., 1992: Evidence Rating: II-1)
   b. Any urinary tract infection should be treated before incontinence therapy is initiated (Lagro-Janssen et al., 1992: Evidence Rating: I) (Ouslander et al., 1989: Evidence Rating: II-2)
   c. Persistent glycosuria, hematuria and proteinuria should be further evaluated by the primary care provider
   d. Resume treatment according to the Clinical Practice Guideline if incontinence persists after successful treatment of urinary tract infection
4. Relevant lifestyle risk factors, medications and mobility status, including dexterity in clothing removal and accessibility of toilet facilities, should be evaluated. Education or intervention directed toward managing or correcting these risk factors should be done prior to or concurrently with initiation of behavioral therapy for incontinence (Tomlinson et al., 1999: Evidence Rating: II-2) (Pearson & Larson, 1992: Evidence Rating: II-3) (Fantl et al., 1996; Pearson & Kelber, 1996: Evidence Rating: III).
   a. Caffeine intake (Tomlinson et al., 1999: Evidence Rating: II-2) (Creighton & Stanton, 1990: Evidence Rating: III)
   b. Fluid intake (Tomlinson et al., 1999: Evidence Rating: II-2) (National Research Council, 1989: Evidence Rating: III)
   c. Smoking (Bump & McClish, 1994: Evidence Rating: II-2) (Pearson & Larson, 1992: Evidence Rating: II-3)
   d. High-impact physical activities (Nygaard, 1995: Evidence Rating: I) (Nygaard et al., 1994: Evidence Rating: III)
   e. Bowel problems, particularly fecal impaction and constipation (Pearson & Larson, 1992: Evidence Rating: II-3) (Resnick & Yalla, 1985: Evidence Rating: III)
   f. Morbid obesity (Bump et al., 1992: Evidence Rating: II-2)
   g. Medications (Diokno et al., 1990: Evidence Rating: II-2) (Fantl et al., 1996: Evidence Rating: III)
   h. Mobility limitations (McDowell et al., 1999: Evidence Rating: I) (Castledon et al., 1985: Evidence Rating: II-2) (McGhee et al., 1997: Evidence Rating: III)

Treatment Decision-Making Process

1. All modifiable risk factors such as urinary tract infection, lifestyle factors, medications and poor mobility should be treated if clinically possible (see the section titled "Basic Evaluation and Clinical Assessment", above) (Fantl et al., 1996: Evidence Rating: III).
2. Education regarding treatment options should be provided to empower the woman to participate with the provider in selecting the appropriate therapeutic approach. The information should include each option with associated risks, benefits and outcomes. Generally, the initial treatment should be the least invasive that is most appropriate for the woman. Discussion should include the woman's perception of the impact of urinary incontinence on her lifestyle and her motivation and preferences for treatment. These issues should also be discussed with family caregivers who are responsible for assisting frail older women with behavioral therapy (Bear et al., 1997: Evidence Rating: II-I) (Rose et al., 1990: Evidence Rating: II-3).
3. Prior to initiating therapy, a bladder diary should be kept by the woman or caregiver if not completed previously (Fantl et al., 1996: Evidence Rating: III).
4. When possible risk factors have been ruled out or treated, women with stress or urge incontinence should receive behavioral therapy that may involve bladder training, pelvic floor muscle training (PFMT) or a combination of both therapies (Burgio et al., 1998; Fantl et al., 1991; Szonyi et al., 1995; Wyman et al., 1997; Wyman et al., 1998; McDowell et al., 1999: Evidence Rating: I)
5. When using a combination therapy approach, it is recommended that bladder training and pelvic floor muscle training be taught separately (McDowell et al., 1999; Wyman et al., 1997: Evidence Rating: I).
6. For women whose lifestyle factors make it difficult to implement or adhere to a behavioral therapy program, timed voiding (e.g., 2-hour toileting) or teaching of urge control strategies may be beneficial (Godec, 1984: Evidence Rating: III).

Interventions

<u>Bladder Training</u>:

1. Bladder training involves a program of patient education, a progressive scheduling regimen and self-monitoring of voiding behavior (Fantl et al., 1991; Lagro-Janssen et al., 1992; Wyman et al., 1997; Szonyi et al., 1995: Evidence Rating: I).
2. The educational program should address the following:
    a. Mechanism underlying continence and incontinence
    b. Brain control of voiding
    c. Urge inhibition strategies involving distraction and relaxation techniques such as:
        - Mind games, e.g., serial subtractions
        - Involvement in other tasks that require significant concentration/attention
        - Use of self statements such as "I can control my bladder"
        - Deep breathing exercises with use of guided imagery
        - Several rapid pelvic floor muscle contractions to quiet bladder urgency

(Fantl et al., 1991; Wyman et al., 1998: Evidence Rating: I) (Wyman & Fantl, 1991: Evidence Rating: III)

3. Based on the pattern of diurnal frequency from the baseline bladder diary, women should be instructed to follow a voiding schedule during their waking hours using the following guide:
    a. If voiding occurs at more than 1-hour intervals, the initial voiding interval should be 1 hour
    b. If voiding occurs at less than 1-hour intervals, the initial voiding interval should be 30 minutes (15 minutes may be used for those women with severe urgency)
    c. In general, most women can be prescribed a 1-hour voiding interval

    (Fantl et al., 1991; Lagro-Janssen et al., 1992; Ramsay et al., 1996; Wyman et al., 1998: Evidence Rating: I) (Wyman & Fantl, 1991: Evidence Rating: III)

4. Women should be instructed to keep a daily log to record their adherence to the scheduling regimen and to note incontinence episodes (Fantl et al., 1991; McDowell et al., 1999; Wyman et al., 1998; Burgio et al., 1998: Evidence Rating: I) (Wyman & Fantl, 1991: Evidence Rating: III).
5. Based on the reduction of incontinence episodes and the tolerance of the voiding schedule, the voiding interval should be adjusted by 15 to 30 minutes on a weekly basis. Tolerance is defined as the ability to adhere to the prescribed schedule without frequent interruptions due to urgency.

    In general, most women will be instructed to increase intervals by 30 minutes per week.

    The goal is to establish a comfortable voiding schedule with the least amount of incontinence episodes. Typically, this will involve a voiding interval of 2 to 3 hours.

    (Fantl et al., 1991; Ramsay et al., 1996; Wyman et al., 1998: Evidence Rating: I) (Wyman & Fantl, 1991; Larsson & Victor, 1992: Evidence Rating: III)

<u>Pelvic Floor Muscle Training</u>:

1. Pelvic floor muscle training consists of repeated, high-intensity pelvic muscle contractions (Lagro-Janssen et al., 1991; Lagro-Janssen et al., 1992; Miller et al., 1998; Nygaard et al., 1996: Evidence Rating: I).
2. A program to build pelvic floor muscle function should be tailored to enhance muscle strength progressively (Doughtery et al., 1993: Evidence Rating: II-1).

    Pelvic floor muscle exercises should be taught during pregnancy and the postpartum period (Sampselle et al., 1998: Evidence Rating: I).

3. Pelvic Floor Muscle Training Protocol: A daily minimum of 30 to 45 pelvic floor muscle contractions (building to a duration of 10 seconds for each contraction) is recommended.

a. These exercises may be done as one set or divided into two or three sets based on the patient's preference
b. At least 10 seconds of relaxation is recommended between each contraction
c. Women should be aware that results may not be apparent until after 6 to 8 weeks
d. Optimal results usually take longer

(Burns et al., 1993; Wyman et al., 1998: Evidence Rating: I) (Doughtery et al., 1993: Evidence Rating: II-1) (Sampselle et al., 1996: Evidence Rating: II-2) (Bishop et al., 1992; Rose et al., 1991: Evidence Rating: II-3) (Miller et al., 1994: Evidence Rating: III)

4. Women should be instructed about self-evaluation and correct pelvic floor muscle training technique (Bump et al., 1991; Sampselle et al., 1996: Evidence Rating: II-2).
    a. Self evaluation:
        - "Drawing in" and "lifting up" of the perivaginal and anal sphincter muscles should be observed (Wall et al., 1993: Evidence Rating: III)
        - Use a mirror to observe downward movement of the clitoris and the drawing in of the anus (Brink et al., 1994: Evidence Rating: III)
        - Perform a digital self-exam (Brink et al., 1994: Evidence Rating: III)
        - Contract the pelvic floor muscle to check ability to stop the flow of urine (no more than once a week) (Sampselle, 1993: Evidence Rating: II-1)
        - During sexual intercourse in which a penis or fingers are inserted into the vagina, check with partner about gripping sensation from pelvic floor muscle contraction (Berghmans et al., 1996; Sampselle, 1990: Evidence Rating: I)
    b. Correct technique:
        - Women should be encouraged to aim for a high level of concentrated effort with each pelvic floor muscle contraction (Bo et al., 1990: Evidence Rating: I) (Doughtery et al., 1993: Evidence Rating: II-1) (Bo, 1995: Evidence Rating: III)
        - There should be no auxiliary (thigh, gluteal) contraction or lifting of buttocks during pelvic floor muscle contractions (Sherman et al., 1997: Evidence Rating: I)
        - Women should be cautioned against bearing down efforts during pelvic floor muscle contractions (Bump et al., 1991; Sampselle et al., 1996: Evidence Rating: II-2)
    c. Monitoring pelvic floor muscle contraction technique performance:
        - Self-monitoring can be accomplished through use of a calendar record (Irsigler & Bali-Tanbald, 1980: Evidence Rating: III)
        - Audiotaped material may aid protocol performance (Wyman et al., 1998: Evidence Rating: I) (Bishop, 1992: Evidence Rating: II-3)
5. Women should be taught to identify situations that cause leakage, e.g., coughing, sneezing and lifting, and to purposefully contract the pelvic floor

muscles when such a situation is imminent (Miller et al., 1998: Evidence Rating: I).

Biofeedback

1. Biofeedback uses electronic or mechanical instruments to relay information to patients about neuromuscular or bladder activity. It aims to alter bladder dysfunction by teaching women to change physiologic responses that mediate bladder control. It also provides a mechanism whereby women can learn the strength of their pelvic muscle contractions. Display of this information through auditory or visual methods forms the core of biofeedback procedures. Measures used for biofeedback include electromyography and manometric measures of pelvic muscle activity and detrusor activity (Stein et al., 1995: Evidence Rating: II-2).
2. Biofeedback can be an adjunct to correct performance of an effective program of pelvic floor muscle technique (Burgio et al., 1998: Evidence Rating: I):
    a. Women who have difficulty isolating or contracting pelvic floor muscles may benefit from biofeedback (Berghmans et al., 1996; Burns et al., 1993; Glavind et al., 1996; McDowell et al., 1999; Sherman et al., 1997: Evidence Rating: I)
    b. One to four biofeedback sessions are usually adequate to enable women to isolate and contract pelvic floor muscles (Burgio et al., 1998: Evidence Rating: I)
3. If a woman cannot isolate and contract the pelvic floor muscles with biofeedback therapy, consider referral for more specialized levels of care (Wall et al., 1993: Evidence Rating: III).

Referral

1. Treatment with or referral for concomitant pharmacotherapy should be undertaken for women who do not benefit from behavioral therapy alone (Holtedahl et al., 1998; Szonyi et al., 1995; Burgio et al., 1998; Wells et al., 1991: Evidence Rating: I) (Smith, 1996: Evidence Rating II-2) (Burns et al., 1993: Evidence Rating: III).
2. Referral for additional evaluation should be made to an appropriate provider for women who exhibit the following conditions:
    - Failed behavioral or drug therapy
    - Significant pelvic organ prolapse
    - Hematuria without infection
    - Complex history or problems based on basic evaluation results requiring additional medical follow-up or specialized therapy
    - History of previous urogynecologic surgery
    - Radical pelvic surgery

    (Bo et al., 1991; Glavind et al., 1996; Lagro-Janssen et al., 1991; Lagro-Janssen et al., 1992; Berghmans et al., 1996; Fantl et al., 1991: Evidence Rating: I) (Stein et al., 1995: Evidence Rating: II-2) (Fantl et al., 1996: Evidence Rating: III)

Refer to the original guideline document for detailed referenced rationales for each clinical practice recommendation.

Quality of Evidence Ratings:

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

II-3: Evidence from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

CLINICAL ALGORITHM(S)

An algorithm is provided for the management of urinary incontinence in women.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Guideline implementation may help the clinician more effectively identify and manage women with or at risk of urinary incontinence, thus reducing incontinent episodes and improving quality of life.

Subgroups Most Likely to Benefit:

Women at higher risk for urinary incontinence (i.e., pregnant and postpartum women; women with visual, cognitive or physical limitations; elderly women) are more likely to benefit from screening activities.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The guideline was developed for the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) as a resource for nursing practice. The guideline does not define a standard of care, nor is it intended to dictate an exclusive course of management. It presents general methods and techniques of practice that are currently acceptable, based on current research and used by recognized authorities. Proper care of individual patients may depend on many individual factors as well as professional judgment. The information presented is not designed to define standards of practice for employment, licensure, discipline, legal or other purposes. Variations and innovations that are consistent with law, and that demonstrably improve the quality of patient care should be encouraged.
- The guideline developers have tried to ensure that drug classifications and selections set forth in this text are in accordance with current recommendations and practice at the time of publication. However, in view of ongoing research, changes in government regulations, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check other available evidence published in referenced resources for each drug for any change in indications and dosage and for added warnings and precautions. This is particularly important when a recommended agent is a new or infrequently employed drug.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Continence for women. Evidence-based practice guideline. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); 2000 Jan. 27 p. [65 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 Jan

GUIDELINE DEVELOPER(S)

Association of Women's Health, Obstetric, and Neonatal Nurses - Professional Association

SOURCE(S) OF FUNDING

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

GUIDELINE COMMITTEE

Evidence-based Clinical Practice Guideline Development Team

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Evidence-based Clinical Practice Guideline Development Team: Molly C. Dougherty, PhD, RN, FAAN, Team Leader; Patricia A. Burns, RN, PhD, FAAN; Della Campbell, MSN, CNS,C., CAN; Carol Susan Johnson, RN, CAN, MPA; Jean F. Wyman, PhD, RN, CS, FAAN.

Reviewers: Diane K. Newman, RNC, MSN, CRNP, FAAN; Carolyn M. Sampselle, PhD, RNC, FAAN; Katherine E. Shelby, MSN, WHNP.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time

Print copies: Available by contacting the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 L Street, N.W. Suite 740, Washington, D.C. 20036; Phone: (800) 354-2268; Web site: www.awhonn.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Evidence-based clinical practice guideline. Continence for women. Monograph. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 Jan. 19 p.
- Continence for women. Quick care guide. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 Jan. 2 p.

Electronic copies: Not available at this time

Print copies: Available by contacting the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 L Street, N.W. Suite 740, Washington, D.C. 20036; Phone: (800) 354-2268; Web site: www.awhonn.org.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on April 9, 2002. The information was verified by the guideline developer on June 7, 2002.

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Date Modified: 11/15/2004